DOCUMENT RESUME

ED 322 450 CG 022 723

AUTHOR Rattner, Leo
TITLE Counseling and Psychotherapy: A Comparative Analysis.
PUB DATE May 88
NOTE 26p.; Paper presented at the Annual Meeting of the North American Society of Adlerian Psychology (36th, Seattle, WA, May 27-30, 1988).
PUB TYPE Speeches/Conference Papers (150) -- Reports - Evaluative/Feasibility (142) -- Viewpoints (120)

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS Comparative Analysis; *Counseling; Counseling Techniques; *Psychotherapy

ABSTRACT

Counseling and psychotherapy are not the same, but rather represent two modalities with different theoretical premises which use different techniques and pursue different goals. Counseling always focuses on a specific subject and the interaction between the counselor and the client is generally goal-directed. The counselor focuses on the acute problem of the client and does not try to change the personality and lifestyle of the client. His task is limited by mutual agreement and counseling is almost always a short-term endeavor. Psychotherapy, on the other hand, is differently structured from the beginning. The problems with which psychotherapy deals are more difficult and more comprehensive than those that are encountered in counseling. The client is considered a patient and the treatment process lasts longer and has a different accent than in counseling. The main focus in psychotherapy is on fundamental changes. While counseling adopts an activistic stance, psychotherapy wants the patient to find his own solution to his problems. After comparing the two treatment modalities, this paper examines the technique of psychotherapy, the personality of the psychotherapist, and the criteria for therapeutic success. (NB)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED322450

COUNSELING AND PSYCHOTHERAPY:

A COMPARATIVE ANALYSIS

by Leo Rattner, Ph.D.

A paper presented at the
36th annual convention
of N.A.S.A.P. in Seattle, WA.,
May 27 - 30, 1988.

CG 022723

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Leo Rattner

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

BEST COPY AVAILABLE

Introduction

A recurring theme that I encounter in my supervisory work with students at the Alfred Adler Institute of New York, is the question: "What is the difference between counseling and psychotherapy?" On the surface this seems like a simple question which can be answered with a few short sentences. But the extended discussion which this topic always stimulates has convinced me that a more comprehensive treatment of the theoretical issues involved might be necessary. This is what I propose to do in today's presentation. I want to look at both these modalities from the point of view of an Adlerian psychotherapist. I shall try to examine their similarities and their differences, with a strong emphasis on what constitutes the distinctive characteristics of psychotherapy as opposed to counseling. At the conclusion of my paper I want to address the fundamental question of what are the indicators for a successful outcome of psychotherapy. This, in turn, is predicated on a conception of mental health, which I shall elaborate and discuss from an Adlerian point of view.

*

Let me begin by emphasizing that counseling and psychotherapy are not the same. Conceptually, we are dealing here with two modalities with different theoretical premises, which use different techniques and pursue different goals.

At best, one could say that counseling and psychotherapy are distantly related, that they have the same historical background and the same genealogy. But as so often happens with members of a family, they have developed along different pathways and had to evolve their own characteristic methods of attaining their specific goals. Therefore it is theoretically and clinically important to stress the differences as well as emphasizing the similarities between the two techniques.

Counseling always focuses on a specific subject. This is already indicated in the nomenclature when we speak of vocational guidance, child guidance or marital counseling. The interaction between the counselor and the person who seeks guidance is therefore generally goal-directed. The client comes for counseling with the expectation that he/she will receive concrete answers to help them resolve a specific, problematic situation. Such answers should also be provided quickly, with a minimum amount of time spent in the counselor's office. It is not expected that the entire life-situation of the client should be examined, that the past should be thoroughly analyzed, and that one tries to understand and to work through the childhood configuration and the life-style of the patient in a comprehensive analytic manner. Counseling is a process which works from the outside. One tries to change the situation in the environment of the client, or to modify those behavior patterns which are negative or destructive and therefore

make the social integration of the client more difficult. The counselor focuses on the acute problem of the client, and tries to help him or her to find the best way to deal with that problem. He does not try to change the personality and the life-style of the client. His task is limited by mutual agreement, and counseling is therefore almost always a short-term endeavor.

Not so in psychotherapy. There the situation is differently structured from the beginning. One looks deeper into the soul of the patient than is the case in counseling. The problems with which psychotherapy deals are more difficult and more comprehensive than those that are encountered in counseling. Psychotherapists also consider the person who comes for treatment more as a patient rather than a client. The treatment process lasts longer and has a different accent than in counseling. Generally, we presume that the patient has the key to the solution of his problems, and that the solution cannot come from the outside. Giving advice to the patient is frowned upon in psychotherapy, although as we shall see later on, the practice looks somewhat different from the theory. But the main focus in psychotherapy is on fundamental changes; e.g. a change in the personality and life-style of the patient, not merely a cosmetic change in the environmental situation or in symptomatic behavior.

In counseling we adopt an activistic stance. We do not hesitate to give advice, to tell the client where he or she

makes mistakes, and how the situation can be changed for the better. In psychotherapy we want the patient to find his own solution to his problems. The therapist is therefore generally more restrained than the counselor. The therapist will not intervene as quickly and as often as the counselor. That does not mean that the therapist always has to remain passive. There are many psychotherapists who confront the patient more actively with his or her problems than I am doing it in my work. But what characterizes analytic psychotherapy is that the main focus is on developing the initiative of the patient. We operate on the assumption that we seek a fundamental change in character and life-style of the patient, and that such a change cannot occur if the therapist provides the patient with all the answers. Greater maturity and increased self-confidence of the patient can only then be realized when the patient becomes an equal and active collaborator in the therapeutic process. The patient must realize that success in psychotherapy depends not only on the skill and personality of the therapist, but also on his own efforts and on the establishment of an effective therapeutic alliance. There is no successful therapy possible when the patient remains a passive participant in the process.

Does the therapist never give advice to his patients? Must he always frustrate the patient who asks the therapist's opinion and who sometimes wants very specific advice? Theoretically, we would have to say "yes" to these

questions. In analytic psychotherapy we do not give advice, although most patients are always trying to bring the therapist into a situation where advice might seem appropriate. This can happen through a direct question: "What should I do now?" Or it could be done in a more sophisticated way, when the patient asks rather off-handedly: "What would you do in my situation?" The latter question is a trap and should be recognized as such. But there are really good reasons why patients who are in psychotherapy should not be given advice. Firstly, we pamper the patient, and we prevent the development of his own initiative and self-confidence. And secondly, we help create a situation where the patient claims all credit for himself if the advice that was offered works out well - which would not be so bad except that it diminishes his sense of reality. But the corollary of this is when the outcome is negative, and the patient blames the therapist with the classical statement: "I only followed your advice." There is no effective rebuttal to that statement, and it is best to acknowledge that a mistake was made by the therapist, and that in the future he should be more cautious about handing out advice.

These are substantive reasons why one should avoid giving advice to the patient in psychotherapy. It is difficult to see how the patient could benefit from the therapist's advice. Yet, there are some situations where we cannot avoid giving the patient some advice and guidance.

These are situations where the patient is likely to endanger his own welfare, where he makes decisions which presumably could confront him with economic, social and emotional stress and which could therefore precipitate an acute crisis. When this happens, it would be very difficult to remain the objective analyst who just observes what the patient is doing and who remains cooly, detached and who abstains from intervention. As therapists and as fellow human beings we want to help the patient to avoid such fundamental mistakes which would bring on an existential crisis from which it would be very difficult to extricate himself.

Even Sigmund Freud was aware of the fact that we cannot always remain objective analysts. In an article which appeared in 1919 under the title "Lines of Advance in Psycho-Analytic Theory," he suggested some modifications of traditional analytic technique. He wrote there:

> Sometimes we cannot avoid accepting patients who are so weak and immature that with them we have to combine analytic work with educational influence. And even with other patients there will be occasions where the physician will have to function as educator and advisor. But this should always be done with great caution, and the patient should not be influenced to identify with us, but to liberate himself and to develop his own identity. (Std. Ed. vol. 17, p. 165)

Thus Freud was apparently less orthodox than many analysts are even today. But it is important to take seriously his admonition that advice should be given only with great

caution. It should not happen too early in therapy, because then we pamper the patient and create the expectation that we will always give advice. And later on, it should also not be done too frequently. Giving advice in therapy is always an exceptional situation, and it is important that therapist and patient are aware of that fact. And I want to emphasize again that advice should only be given when the patient is in an acute emotional crisis from which he is unable to extricate himself. What I have tried to demonstrate with these observations is that there is a fluid transition between counseling and psychotherapy. But the movement between these two modalities is generally in one direction only. When a counselor realizes that the client's problems are more serious than was previously recognized, he or she will frequently recommend psychotherapy for the client. A reverse development is difficult to imagine. It could happen that during the first session - in the initial interview - the therapist reaches the conclusion that it is a relatively simple problem and that the individual who seeks help could do just as well with competent counseling. But I don't know of any single case where therapy is already further advanced, where patient and therapist are actively engaged in the therapeutic process, that the therapist would have found it necessary to terminate the therapy and to recommend short-term counseling instead.

******

The Technique of Psychotherapy

The difference between counseling and psychotherapy becomes most clearly apparent when we compare the techniques of the two modalities. Counseling depends on a quick assessment of the client's personality and life-style, and the ability to offer concrete, specific suggestions how to resolve the problematic situation. In psychotherapy, we can afford to wait longer until the fundamental problems of the patient are revealed in the therapeutic process. Time pressure exists in the application of both modalities. But it is generally understood by both patient and therapist from the beginning, that psychotherapy will last longer and that no quick, immediate results can be expected. Perhaps, many of you know already that therapy is not so much a treatment - a term which connotes the medical model - but rather a process. But how does this process work? Which factors lead to the fundamental change that we call a cure? What causes genuine improvement in the adaptive behavior of the patient which will help him to realize his potential for love and communal integration? The fact is that although psychoanalysis has existed for more than eight decades, and a lot has been written about the technique of psychotherapy, very little serious research has been done about the concrete factors which account for a cure. There are, however, general principles which are valid for the members of most therapeutic schools, and it is these principles that I want

to discuss briefly today. In my own experience, they represent the foundation which can best explain why psychotherapy succeeds, or conversely, why it frequently fails.

Every analytic psychotherapy must deal with the basic behavior patterns and with the emotional structures which were developed in the mother-child relationship, and which are the foundation for the subsequent development of personality. Psychotherapy, we might say, wants to bring out the child that lives in all of us. It starts from the assumption that the most important aspect in the life of each person is the quality of the interpersonal relationships, and that we can understand the characteristic pattern of these relationships only when we know and understand how the individual experienced these relationships in his childhood. We focus therefore on relations with parents and siblings and with significant others in the environment of the child, such as relatives, teachers and friends. And from the memories, early recollections and free associations of the patients do we try to draw conclusions about their real feelings and motivations in these important relationships. In other words, we want to find out how it really was, what the patient truly experienced, and not how it has been embellished in idealized memories. Because it is another axiom of analytic psychotherapy that the disturbed interpersonal relationships of the present can only then be changed when we understand what the patient experienced in the past, and how these disturbing experiences were absorbed and

integrated into the personality and life-style of the patient.

Otto Fenichel, a student of Freud, maintains that every procedure which attempts to overcome resistance and which interprets transference can be called psychoanalysis, regardless of whether the patient lies on the couch or sits opposite the therapist. I don't know whether this is a compliment or simply the recognition of the fact that analytic work does not have to be tied to all aspects of the Freudian technique. At any rate, we do all agree that the basic factor in analytic work is the interpretation of unconscious material which is manifested in free associations and in dreams. Free associations and dreams are the raw material with which therapy works. The success of therapy depends on the ability to achieve genuine cooperation between patient and therapist, and such cooperation is characterized by the fact that the process of free association can be activated through all phases of psychotherapy. A main feature of therapeutic work consists in overcoming resistance which hinders the flow of free associations.

In general, the therapist should keep to the material which the patient brings to the sessions. He has his own associations to that material, but he should not try to impose these on the patient. With many beginning therapists there is a tendency to push their own agenda on the patient. Being somewhat anxious to prove their own effectiveness as therapists they try to steer the patient into a direction

which they consider valid, want to analyze only those themes which they consider appropriate for their patients. Perhaps they are also confused about the difference between counseling and psychotherapy, and feel pressured to produce quick results. Be that as it may, when I see such an approach with my students in supervision, I tell them clearly and directly that they should stop doing that. It leads always to a justified resistance of the patient who rebels against therapy because he does not feel properly understood by the therapist. And indeed, we must assume that there is more countertransference at work here than the therapist is consciously aware of.

The art of psychotherapy is not to give the patient your own interpretations, but to try to bring the patient to the point where he is able to interpret his own associations, dreams and behavior patterns. This works best through the use of the Socratic method. Adler, as you know, placed great emphasis on the use of the Socratic method. This technique is based on the dialectic which rests on the assumption that the truth can best be found through a discussion between two participants in which each discussant represents a diametrically opposed viewpoint. In the ongoing discussion, eventually a synthesis of the two opposing viewpoints is achieved which comes closer to the truth than either one of the two discussants previously had. Socrates also believed that it might be possible to explore one's own soul to find the answer to the existential problems of life.

But it is clear from the dialogues of Plato that this method is less satisfactory than the discussion between two people who are both trying to find the truth.

Truth in psychotherapy is being sought through the establishing of hypotheses and the testing of the validity of these hypotheses. Thus, therapy is not very different from the Platonic dialogues. The therapist focuses initially on the empathic listening to the free associations, memories and dreams of the patient. Based on this raw material he develops certain hypotheses about the problems and conflicts of the patient. With the help of the Socratic method he tries to convey to the patient these hypotheses, and when the patient achieves intellectual and emotional insights which he considers valid for himself, then we have some proof for the validity of the original hypothesis. Sometimes, these hypotheses have to be changed, modified or completely abandoned, and have to be replaced by new and better hypotheses. But in the last analysis, it is always the insight of the patient which is the yardstick for the validity of a therapeutic hypothesis. Because it is only through the patient's awareness and insight that therapeutic improvement can be accomplished, even though one has to be aware that there is often a time interval until the patient is able to assimilate the insights he has gained in therapy and to change his life-situation.

Insight can be cognitive-intellectual as well as emotional. Important is always how insight is being utilized.

Yet, in the final analysis the emotional awareness is of greater significance for the progress of therapy, especially if it can be mobilized by the patient for the achievement of further progress. One always observes how the patient reacts to the interpretations given by the therapist. If the patient reacts with emotional affect - such as anger, crying, being thoughtful - then one can assume that the interpretation has a certain validity. The ultimate proof of that is that the patient is able to bring new material into consciousness, such as early recollections, dreams and memories from the past.

When we speak of insight and that insight leads to improvement, we have to be aware that there is a certain time lag between insight and genuine emotional change. Most theorists would agree today that insight only prepares the ground for clinically noticeable improvements. It seems as if insight has to be absorbed and integrated before it can manifest itself in different behavior patterns. This working through process can take weeks and sometimes months until it reveals itself as therapeutic progress. But during all this time one has a sense of movement. One knows that something positive is happening in therapy, and that the results will be visible in the near future.

The ultimate test for the success of psychotherapy is the growing ability of the patient to cope with the world, his greater emotional maturity. We agree with Erich Fromm that a criterion for therapeutic success is the increased

ability of the patient to think logically, to be able to love and to work productively. Therapy is different in that respect from counseling which pursues more limited goals. We might say that psychotherapy ultimately wants to be a life-changing process while counseling has more modest ambitions. And it must also be emphasized that therapy cannot be an indoctrination. The patient will not be influenced by preaching, by attempts to logically convince him to change his basically irrational personality structure. For that it needs a solid analytic psychotherapy which addresses the genuine emotional needs of the patient, and which helps the patient to understand himself better and to find better solutions for his emotional and interpersonal problems.

The Personality of the Psychotherapist

This brings us to a key element for a successful psychotherapy - the personality of the therapist. All therapeutic schools agree on that point, namely that the personality and the behavior of the therapist are decisive factors for the success of therapy. Research has shown that there is a definite correlation between three personal qualities of the therapist and a successful outcome of therapy. These three qualities are: a harmony or congruence between what the therapist says and what he feels; an ability to develop and to demonstrate empathy, and the ability to accept the

patient, to have positive regard for that person without any equivocation. It seems that the possession of these abilities is ultimately even more important than technical competence, though the latter is of course also quite important.

Personality and behavior of the therapist are decisive for therapeutic success. That means how the therapist behaves concretely, how he leads his own life, how he fulfills his professional obligations. All these factors the patient eventually realizes, even though his impressions may not always be verbalized. But it is an illusion to assume that the therapist will remain forever a blank screen for the patient. Therefore, it is better when the therapist is a person who leads an authentic existence, who leads such a life that he can be a role model for the patient in the vital aspect of the possibility of greater social interest and of mental health. A neurotic therapist - and unfortunately there are many such around - will impose many elements of his own neurotic tendencies on the patient. What Jung said many decades ago, that we cannot help the patient to progress further than we have come in our own analysis, still holds true today. The development of genuine trust between patient and therapist - which is a basic supposition for therapeutic success - can only then occur when the therapist's concrete behavior encourages the patient to give up his defense mechanisms. We can say a priori, that the therapist who is not sufficiently analyzed, who is still stuck in his own neurosis, will hardly be able to accomplish

this process which is of vital significance for the success of therapy.

The second therapeutic requirement is empathy. Empathy is comparable to an artistic ability, we might say that it is the real art in psychotherapy. Empathy is the ability to feel with the patient, to meet him on the same emotional wavelength. Adler defined empathy as "the ability to see with the eyes of another, to hear with the ears of another, to feel with the heart of another." I don't believe that we have ever had a better or more concise definition of empathy in the last five decades.

Concretely speaking, empathy is manifested in the ability to listen to the patient without one's attention being diverted, and in the manner of verbal communication which should express that conscious as well as unconscious communications of the patient were understood. The ability to listen with freefloating attention - which Freud already recommended - is very difficult to learn, and it takes many years of training until the therapist masters this skill. Some therapists always remain stuck on the surface. They hear only that which they can tolerate emotionally. We know today that many therapists can be easily sidetracked, and that very often they want to avoid hearing that which could arouse anxiety within themselves. And it is clear that we cannot expect the patient to deal with a problem which the therapist himself has not been able to master.

The ability to accept the patient completely and to

make no value judgments is self-understood and should need no further justification. In therapy, many people have for the first time the experience to be accepted on the basis of equality, and it is this experience which provides a building block for the establishment of a trusting therapeutic relationship. But to attain such a goal, the therapist must have an anti-authoritarian attitude. He must have overcome his own inferiority feelings as well as his drive for power to such an extent that these feelings are not projected on the patient. Only when we ourselves genuinely believe in the equality and equal validity of all human beings, when we accept our own humanity, can we convey to the patient that he is an equal collaborator in the therapeutic process. We must always be aware - as Adler pointed out - that it is only an historical accident that we sit in the therapist's chair and the patient in his chair, and that the opposite could easily have been the case.

Finally, when we ask ourselves which factors are responsible for therapeutic progress, then we cannot overlook the influence of theory. It is clear that we need a theoretical orientation to understand what happens in therapy, why we do what we do, and which goals we try to attain in therapy. If we had no theory or technique which is based on theory, then communication with the patient would only be like a conversation between two friends. But if we wanted to understand and categorize all problems according to a textbook description, then we would conduct therapy only on the intellectual level and the emotional experience would be missing. A good

therapist uses theory not as a rigid structure. It should not be like a mold into which the patient has to be forced. Rather I would suggest that the therapist should be sufficiently flexible to adapt the therapy to the needs of the individual patient. There are always situations in therapy for which no textbook and no theory has prepared us adequately. In such situations, we must find within ourselves the ability to react in such a way that it helps the patient to advance further in his own analysis. Without theory ~~was~~ we are like a ship that sails on the ocean without a good compass. But the compass shows us only the general direction; it gives us general guidelines. It is our task as therapists to use these guidelines creatively, to fill them with meanirgful emotional content. The emotional experience in therapy is always more important than theoretical jargon. A good therapist will therefore rarely use theoretical terminology when he communicates with the patient. Rather, he will always try to use the patient's own words to make him aware of his emotional structure.

The Final Phase of Therapy: Criteria for Therapeutic Success

How do we know that psychotherapy is successful? Which criteria can we use to define concretely therapeutic success? Perhaps it would be interesting to answer these questions with a brief comparison of the theoretical

conceptions of the various therapeutic schools. In Freudian analysis, the final goal of therapy is the manifest ability of the patient to love and to work. Adler agreed with these goals, but looked additionally for a change in life-style and the development of greater social interest. Jung focused on the integration of the various functions of the patient's personality. Harry Stack Sullivan sought a genuine, spontaneous emotional experience in interpersonal relationships. Erich Fromm would have said that the purpose of psychotherapy is to help the patient to realize his potential, despite the fact that we live in a imperfect, irrational world. And Karen Horney wanted to help the patient to accept himself or herself more completely, and to realize his true self in a constructive relationship with other human beings. All these goals seem to me to have a common core content. They are not so much conflicting theses but rather variations on a specific theme; namely the necessity for the patient to seek not only symptomatic relief but to strive for a more fundamental change of personality and life-style which will facilitate mental health in the present and in the future.

What criteria can we use to measure these results? It is true that there are as yet no truly scientific measurements which could guide us in this task. But when we observe our patients carefully, we can see certain changes which indicate a positive transformation to the trained observer. The first criterion is the increased ability of

the patient to see himself more realistically, to see himself or herself how he really is and not how he would like to appear to himself or others. Therapy always confronts the patient with the contradictions between his emotional premises and reality. He learns to see the difference between his idealized self-image and the hidden inferiority feelings, the dichotomy between the impression he believes he is making on others and the real effect that he produces. This is a painful but necessary process in psychotherapy. The perception of the discrepancies between reality and fantasy provides a powerful stimulus for emotional change in a direction which is supported by cognitive insight. The patient who becomes more realistic and more rational is definitely making progress in his therapy. It is this element of greater connectedness to the reality of life that we consider a valid criterion for therapeutic success. What Adler defined as rationality (Sachlichkeit), and Erich Fromm characterized as the ability to think logically, are the categories which we view as indications of genuine therapeutic progress when they are manifested in the therapeutic process.

The second criterion is a stronger optimistic attitude on the part of the patient. Almost all patients are demoralized and pessimistic about their ability to lead a constructive life at the beginning of therapy. Deep down, such patients do not believe that they can ever experience a feeling of contentment or happiness in their life, and that

the future could be better than the past or the gloomy present which they experience daily. Psychotherapy must deal with this feeling of existential despair because real therapeutic progress is not possible as long as the patient has not liberated himself from his discouraged attitude towards life and its problems. Therefore, we constantly look for signs which indicate more courage and greater optimism on the part of the patient. Generally, this happens when the patient develops new insights, when he becomes aware of thoughts and feelings whose origins and motivations were unconscious until now, or were not properly understood - to use Adler's formulation. Such insights facilitate a feeling of his own achievement for the patient, which is re-enforced by the therapist's emphasis that all therapeutic progress is ultimately due to the efforts of the patient. All successful therapies work towards changing the self-image of the patient. Instead of seeing himself or herself as a person who is overwhelmed by his problems and symptoms, the patient learns to view himself as a human being who can realistically cope with his problems. Instead of the professional pessimism which is characteristic for all neuroses, we eventually hope to see a more open, life-affirming attitude which is an integral part of mental health.

This conception views symptomatic change as less important. It is true that symptomatic improvement or the giving up of a symptom always characterizes a successful

therapy. But this should happen spontaneously if therapy is handled properly. It should flow organically out of the therapeutic process, and should not occur in a way which cannot be understood through the process of psychotherapy. As we all know, it frequently happens that the patient gives up a symptom because he wants to convince himself and the therapist that he is already healthy and therefore does not need any further therapy. The flight into health is a negative phenomenon which Freud already recognized, and of which he warned us many decades ago.

As Adlerians we are also looking for an expanded social interest on the part of the patient. This is the last and most important criterion of mental health, which includes the other aspects mentioned before. Greater rationality and more courage to face the three life tasks are basic ingredients of social interest. Therefore, for us the final yardstick for the success of therapy is whether the patient manifests more social interest than he or she demonstrated at the beginning of therapy. And we are looking here for concrete, active manifestations of social interest and not just rhetorical comments. It is rather easy to get excited about poverty and misery in Asia, Africa or South America. It is much more difficult to demonstrate fellow human feeling in our own life-sphere - in the relationship to spouse, children, friends and even strangers - with whom we have to share the limited resources of this "poor planet earth." (Adler).

Summary and Conclusions

At the conclusion of my presentation, I want to emphasize once more the difference between counseling and psychotherapy. In counseling, we know our job has been done once the specific problem of the client has been resolved. In psychotherapy, symptomatic improvement is often only the beginning of our task. Counseling, we might say is concerned with problem-solving; psychotherapy is concerned with healing the whole person. And if we aim for a life-changing, life-affirming resolution of ~~one~~ our patients' problems, then we have to settle down for the long haul. There are no shortcuts, no magic recipes available for this endeavor. The essential qualities that the therapist has to bring to this task, are the ability to listen with empathy and to be patient through out the trials and tribulations of the therapeutic process. Without these qualities, the therapist will not be able to succeed, no matter how intelligent or knowledgeable he might otherwise be. The possibility of therapeutic success is greatly increased, however, when we address the fundamental concerns of the patient with patience and perseverance and with respect for the dignity of the person who seeks our help. After working for more than 30 years as a psychotherapist, this is still the best and most hopeful advice that I can offer to my students.

This brings me to the last point of my presentation. Analytic psychotherapy is a dynamic process. It always aims

for movement and tries to stimulate change in the patient. Such change occurs on many levels. It is a symptomatic change, a cognitive-emotional change and a change in the basic behavior patterns in interpersonal relationships. To create the best possible conditions for such changes in the personality and life-style of the patient, the therapist himself must have mature social interest. He or she must be a genuine fellow human being and must be experienced as such by the patient. If this condition exists, then we don't need to preach to the patient to convince him of the necessity of greater social interest. And if the therapist does not have enough social interest, if it is not sufficiently developed, then ten years of talking to the patient will not motivate him to develop more social interest. If the patient cannot experience the therapist as a genuine human being, then we can neither expect nor demand that he should develop the necessary strength and courage to succeed in the therapeutic process. Psychotherapy will become stagnant and ultimately fail, because a genuine interpersonal relationship and interaction between patient and therapist did not occur. Such a relationship, however, is the indispensable premise for the success of the process that we call dynamic, analytic Adlerian psychotherapy.

******

Leo Rattner, Ph.D.
69-40 108th Street
Forest Hills, N.Y. 11375